COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

OFFICE OF OVERSIGHT AND INVESTIGATIONS
MAJORITY STAFF

IMPLEMENTING HEALTH INSURANCE REFORM: NEW MEDICAL LOSS RATIO INFORMATION FOR POLICYMAKERS AND CONSUMERS

Staff Report for Chairman Rockefeller
April 15, 2010

Executive Summary

Since August 2009, the Senate Commerce Committee has been investigating how commercial insurance companies spend the billions of dollars of premiums that American consumers pay them every year for health care coverage. One of the basic financial indicators that insurers, investors, insurance commissioners, and policymakers look at to understand how premium dollars are being used is the "medical loss ratio." This staff report provides an update on the Committee's investigation, including a review of new 2009 medical loss ratio information that health insurers recently filed with their regulators.

The 2009 medical loss ratio results shows that there continues to be a large disparity between patient medical spending in the large group market, and spending in the individual and small group markets. According to their own data, last year the largest insurers used about 15 cents out of every large group premium dollar for administrative costs and profits, while more than 26 cents out of every premium dollar went to administrative costs and profits in the individual market.

This staff report also discusses the new minimum medical loss ratios that became law as part of the health care reform legislation President Obama signed last month. The goal of the medical loss ratio provision of the new health care law is to make sure that consumers get the full benefit of the health care premiums they pay insurers. As this report discusses, the insurance industry is beginning to consider the financial impact of the new minimum medical loss ratio requirements. At least one company, WellPoint, has already "reclassified" more than half a billion dollars of administrative expenses as medical expenses, and a leading industry analyst recently released a report explaining how the new law gives for-profit insurers a powerful new incentive to "MLR shift" their previously identified administrative expenses.

As the National Association of Insurance Commissioners (NAIC) and the Department of Health and Human Services (HHS) work to implement the new statutorily required medical loss ratios, they need to make sure that insurers are spending consumers' premium dollars on delivering health care and improving the quality of this care. Boosting medical loss ratios through creative accounting will not fulfill the new law's goal of helping consumers realize the full value of their health insurance payments.

I. Background on the Medical Loss Ratio

In the commercial health insurance industry, "medical loss ratio" refers to the percentage of each premium dollar that insurers spend on providing health care to their customers. For example, if an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay expenses that do not directly benefit policyholders, such as salaries, advertising, agent commissions, overhead, and profits.

Regulators, policymakers, and investors look to the medical loss ratio as a basic indicator of an insurer's efficiency in delivering services and of its financial condition. While investors

view a stable or declining medical loss ratio as an indicator that an insurer is controlling risk and is more likely to be profitable, consumers and policymakers view low medical loss ratios as evidence that an insurer is spending too much money on administration and profits, and not enough on medical care.[1]

In order to make sure that consumers are getting sufficient value for their health insurance premium dollars, many states have established "minimum medical loss ratios," which require insurers to spend greater than a specified percentage of every premium dollar on medical care. For example, the State of New Jersey requires all insurers selling individual health care policies in the state to maintain a medical loss ratio of 80% or higher.[2] The health care reform bill signed into law in March 2010 established for the first time federally required minimum medical loss ratios in the individual and group health insurance markets.

II. The Commerce Committee's Investigation

On August 21, 2009, the Senate Commerce Committee opened an investigation into the health insurance industry focusing on medical loss ratios. Chairman Rockefeller sent letters to the 15 largest health insurers asking for more information about how these companies spend their policyholders' premium dollars. The letters asked the companies to provide medical loss ratio information broken down by state, and by the individual, small group, and large group market segments.

While most of the companies that received the August 21 letter responded voluntarily to the Chairman's request, the largest for-profit health insurers resisted Chairman Rockefeller's request for medical loss ratio broken down by market segment and state. Although these companies routinely provide overall medical loss ratio data to their investors in financial filings and conference calls, they informed the Committee that medical loss ratio information broken down by state and market segment was "proprietary" and "business sensitive." These companies' failure to voluntarily provide this information was troubling because segmented medical loss ratios are extremely useful information for individuals or small businesses trying to purchase health insurance in a particular market.

Because the largest for-profit companies were reluctant to voluntarily share their medical loss information broken out in a way that would be helpful for consumers, the Committee began collecting this information from 2008 "Accident & Health Policy Experience Exhibit" forms that the companies filed with the National Association of Insurance Commissioners (NAIC). Chairman Rockefeller presented an analysis of this segment-by-segment medical loss ratio

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[1] For an extended discussion of medical loss ratios, see Letter from Chairman Rockefeller to Mr. H. Edward Hanway, Chairman and CEO of CIGNA (Nov. 2, 2009)(online at: http://commerce.senate.gov/public/index.cfm?p=HearingsandPressReleases&ContentRecord_id=dab514f7-1fc7-496b-a8b8-712987792fa8&ContentType_id=77eb43da-aa94-497d-a73f-5c951ff72372&Group_id=165806cd-d931-4605-aa86-7fafc5fd3536&MonthDisplay=11&YearDisplay=2009).

[2] N.J. Stat. Ann. §17B:27A-25 and §17B:27A-9, as amended by S.B. 1557 (2008).

information in a letter he sent to the CEO of CIGNA, Mr. Edward Hanway, on November 2, 2009.[3]

The analysis found that the largest for-profit health insurers spend a lower percentage of their customers' premium dollars on patient care than other health insurers. The analysis also found that in the individual and small group markets, health insurers spend a significantly smaller portion of each premium dollar on medical care than they do in the large group market. For example, UnitedHealth told its investors that the company's overall 2008 medical loss ratio was 82%.[4] But the NAIC filings revealed that the company's medical loss ratio was 71% in the individual market, 79% in the small group market, and 84% in the large group market.[5]

III. New Medical Loss Ratio Information from Recent 2009 Regulatory Filings

Insurers recently filed their 2009 Accident and Health Experience Exhibits and Committee staff has reviewed the medical loss information the six largest for-profit companies provided in these filings. The 2009 data, along with an updated version of the 2008 data, are presented in a summary table below (Table I) and in more detailed tables at the end of this report.

	Individual		Small Group		Large Group	
	2009	**2008**	**2009**	**2008**	**2009**	**2008**
Aetna	75.7%	73.9%	84.2%	82.0%	87.2%	82.0%
CIGNA	88.1%	86.9%	92.1%	---	85.2%	37.2%
Coventry	71.9%	65.8%	78.2%	79.1%	86.0%	82.7%
Humana	68.1%	71.9%	80.0%	77.2%	88.2%	82.4%
UnitedHealth	70.5%	70.3%	81.1%	78.7%	83.3%	83.5%
WellPoint	74.9%	73.1%	81.2%	79.0%	84.9%	85.2%
TOTAL	**73.6%**	**72.5%**	**81.2%**	**79.7%**	**85.1%**	**83.9%**

TABLE I – 2009 Medical Loss Ratios by Market Segment – Largest For-Profit Insurers

The data presented in these tables show that the largest for-profit insurers modestly increased the percentage of premium dollars they spent on medical care in 2009. But the 2009 data also show that despite these increases, the disparities in medical spending between market segments remained as large as ever. Demonstrating a spread of more than 11 percentage points, insurers extracted a larger portion of premium dollars paid by their individual and small business customers for administration and profits than they did for their large group customers. For example, while these six insurers used about 15 cents out of every large group premium dollar

[3] *Supra*, note 1.

[4] *Id.*

[5] *Id.*

for medical expenses, they used more than 26 cents out of every individual premium dollar for medical expenses.

IV. Medical Loss Ratios in the Health Care Reform Legislation

In response to concerns that insurers were not spending a large enough portion of health insurance premiums on medical care in the individual and small business markets, Congress created federally required minimum medical loss ratio requirements in the Patient Protection and Affordable Care Act (PPACA), the health care reforms President Obama signed into law on March 23, 2010.[6] Under the law, starting in 2011, insurers will have to meet minimum medical loss ratios or else provide rebates to consumers based on the amount insurers' spending falls below these minimums. PPACA establishes a minimum loss ratio of 80% for the individual and small group health insurance segments, and 85% for the large group segment. The decision to establish minimum medical loss ratios at these levels was guided by the Congressional Budget Office's determination that the majority of insurers were already providing benefits to their customers at or above these levels.[7]

The following example illustrates how this rebate process will work under the new law: if an insurer collected $100 million in premiums from business owners for small group coverage, but only spent 78% of these premiums on medical care, the law requires the insurer to rebate 2% of the premiums collected ($2 million) to the policyholders on a pro rata basis.

A crucial issue in the implementation of this provision is clarifying which expenditures insurance companies will be able to consider medical expenses and which expenditures they will have to treat as administrative.[8] While NAIC accounting rules define "medical loss" as the value of medical claims an insurer has actually paid ("incurred claims"), plus the amount of money the insurer sets aside to pay future claims ("contract reserves"), the new law will potentially allow insurers to classify a broader set of expenditures as medical.[9]

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[6] Sec. 2718 of Title XXVII, Part A of the Public Health Service Act, as added by Sec. 10101(a) of Title X of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010) (hereinafter "PPACA MLR provision").

[7] Congressional Budget Office, *Budgetary Treatment of Proposals to Regulate Medical Loss Ratios* (Dec. 13, 2009) (online at: http://www.cbo.gov/ftpdocs/107xx/doc10731/MLR_and_budgetary_treatment.pdf).

[8] In the insurance industry, non-medical expenses are generally called "SG&A" (Sales, General and Administrative) expenses.

[9] NAIC's instructions for the 2008 Accident & Health Policy Experience Exhibit define "loss ratio" as "the ratio of Incurred Claims (Column 2) plus the Change in Contract Reserves (Column 3) to Earned Premiums (Column 1)." *Official NAIC Annual Statement Instructions: Health*, 359 (Aug. 2008). NAIC accounting guidelines currently allow insurers to designate certain non-claims expenses as "cost containment expenses." These expenses include fraud prevention, case management, network access fees, and consumer education. NAIC, *SSAP No. 85: Claims Adjustment Expenses, Amendments to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* (June 10, 2002).

Under the new law, insurers will be able to consider expenditures on "activities that improve health care quality" as medical expenses for the purpose of calculating medical loss ratios.[10] For example, if an insurer spends 78% of its small group premiums paying claims and 2% on quality-improving activities, it will have met the law's 80% minimum medical loss ratio requirement. The law instructs the National Association of Insurance Commissioners, subject to the certification of the Secretary of Health and Human Services, to establish uniform definitions of "activities that improve health care quality" and "non-claims costs." [11]

V. Implications of the New Law on the Commercial Health Industry

Any health insurer currently spending less than the new federally-established minimum medical loss ratios on medical claims can continue doing so, but will be subject to the law's rebate requirements. The new law therefore creates new incentives for insurers to make changes to their cost structures and their accounting practices that may raise their medical loss ratios to the new minimum levels of 80% in the individual and small group segments, and 85% in the large group segment. As the example discussed above illustrated, if the insurer spending 78% on small group claims can find a way to classify 2% of its expenditures as medical instead of administrative, it can retain the $2 million it would have otherwise had to return to its policyholders.

Both insurance companies and industry analysts have started recognizing that the implementation of the PPACA's "quality of care" expense category will have a major impact on the insurance industry's bottom line over the next several years. A recent announcement about accounting changes by insurance giant WellPoint is a first indication of how for-profit insurers will approach this issue. In the company's most recent investor call, WellPoint executives announced that the company has started "reclassifying" certain expenses that the company had traditionally classified as administrative expenses. This reclassification involved expenditures on the following items:

- "Nurse hotline";
- "Health and wellness, including disease management and medical management"; and
- "Clinical health policy."[12]

By reclassifying these expenses as medical benefits, the executives projected that WellPoint's 2010 medical loss ratio (which the company calls its "benefit expense ratio") would increase by 170 basis points, or 1.7%.[13] Because WellPoint expects to collect more than $30

[10] PPACA MLR provision, (b)(1). This subsection also allows insurers to subtract certain tax payments and fees from their premium calculation.

[11] PPACA MLR provision, (c).

[12] WellPoint investor call and PowerPoint presentation, "WellPoint, Inc. 2010 Financial Outlook Review," at 9 (Mar. 17, 2009) (online at: http://ir.wellpoint.com/phoenix.zhtml?c=130104&p=irol-calendar).

[13] *Id,* at 8.

billion in premiums from its commercial health care customers in 2010, this "accounting reclassification" means that the company has converted more than a half a billion dollars of this year's administrative expenses into medical expenses.

A report issued by health care industry analyst Carl McDonald of Oppenheimer & Co., on April 8, 2010, directly addresses the financial implications for-profit health insurers will face when the new minimum medical loss ratios go into effect next year.[14] McDonald predicts that companies will review their current spending and attempt to shift as many expenses as possible from administrative to medical. In one scenario, McDonald posits an "MLR shift" of 500 basis points, or 5%. He concludes that a key to the insurance industry's profitability over the next several years will be "how much MLR recharacterization the HHS Secretary allows."[15]

A crucial part of this profitability analysis is understanding how the new minimum medical loss ratio requirements will affect insurers at the "statutory entity" level. The medical loss ratio data presented in Table I of this report represents an average of the financial performance of the six companies' numerous subsidiaries. WellPoint's numbers, for example, represent the combined medical loss ratios of 27 separate statutory entities, and there is a broad range of medical loss ratios among these entities.[16]

Table II below presents the 2009 medical loss ratios of six large, state-based WellPoint subsidiaries. A table at the end of this report presents the 2009 data that all of WellPoint's subsidiaries have filed to date with the NAIC. These results show that some WellPoint subsidiaries have medical loss ratios in particular markets that already exceed the minimum medical loss ratios set in the new health care reform bill. Examples are Blue Cross Blue Shield of Georgia's large group business (86%) and Anthem of Kentucky's small group business (80.9%).

	Individual	Small Group	Large Group
Anthem Health Plans of NH	62.9%	87.9%	88.4%
Anthem Health Plans of VA	72.1%	66.6%	79.4%
Rocky Mountain Hospital & Medical	74.1%	79.9%	83.1%
Blue Cross Blue Shield of GA	75.5%	78.0%	86.0%
Anthem Health Plans of KY	79.4%	80.9%	82.0%
Anthem Health Plans of ME	95.2%	86.9%	89.5%

TABLE II – 2009 Medical Loss Ratios for Selected WellPoint Subsidiaries

[14] Carl McDonald and James Naklicki, Oppenheimer & Co. Inc. Equity Research Industry Update, *The Average Person Thinks He Isn't – Minimum Medical Loss Ratio Analysis* (Apr. 8, 2010).

[15] *Id*, at 1.

[16] The NAIC data does not contain information about the WellPoint subsidiary Blue Cross of California, since that subsidiary is regulated by the California Department of Managed Health Care.

But many other subsidiaries have medical loss ratios that fall below – and sometimes significantly below – the new minimum standards in particular markets. For example, Blue Cross Blue Shield of Georgia's 2009 medical loss ratio in the individual market (75.5%) is 4.5% below the new federal minimum, and Anthem of Kentucky's large group ratio (82%) is 3% below the new minimum. As the Oppenheimer report points out, markets where WellPoint subsidiaries have low medical loss ratios are "the most profitable tail" of WellPoint's business. The threat the new minimum medical loss ratios pose to insurers like WellPoint is that once the law is applied to these markets, "these very profitable regions immediately have to become markets of average profitability, whereas the less profitable markets stay less profitable."[17]

Given this dynamic, companies that have medical loss ratios below 80% in the individual and small groups markets, and below 85% in the large group market, will be under pressure to perform "MLR shifts" that bring their ratios closer to the new federal minimums. Every basis point these companies can shift from the "administrative" to the "medical" expense column is money these companies can retain as potential profit, rather than refund to their policyholders. In response to these pressures, the Department of Health and Human Services and state insurance commissioners will have to remain vigilant and focused on ensuring that consumers get the benefit of the new federally mandated medical loss ratios.

[17] *Id*, at 2.

Premiums, Claims, and Loss Ratios

Comprehensive Major Medical Insurance for the 6 Largest Public Insurance Companies (2009)

	Individual			Small Employer			Large Employer		
	Premiums	*Paid Claims + Change in Contract Reserves*	***Loss Ratio***	*Premiums*	*Paid Claims + Change in Contract Reserves*	***Loss Ratio***	*Premiums*	*Paid Claims + Change in Contract Reserves*	***Loss Ratio***
Aetna	$1,067,373,961	$808,241,274	**75.7%**	$4,152,377,642	$3,495,634,331	**84.2%**	$10,751,303,688	$9,378,310,007	**87.2%**
CIGNA	$67,909,705	$59,807,847	**88.1%**	$171,979,619	$158,473,605	**92.1%**	$4,281,882,762	$3,647,976,925	**85.2%**
Coventry	$189,101,595	$136,043,183	**71.9%**	$1,691,895,784	$1,322,747,647	**78.2%**	$2,643,919,441	$2,273,910,960	**86.0%**
Humana	$602,807,555	$410,241,077	**68.1%**	$2,127,994,874	$1,703,155,307	**80.0%**	$3,040,915,262	$2,683,218,711	**88.2%**
UnitedHealth	$1,749,375,707	$1,233,295,538	**70.5%**	$11,013,011,550	$8,930,641,286	**81.1%**	$17,907,779,538	$14,910,470,924	**83.3%**
WellPoint	$4,429,058,685	$3,318,569,293	**74.9%**	$8,678,606,642	$7,050,269,009	**81.2%**	$11,840,078,917	$10,051,310,004	**84.9%**
Total	**$8,105,627,208**	**$5,966,198,212**	**73.6%**	**$27,835,866,111**	**$22,600,921,185**	**81.2%**	**$50,465,879,608**	**$42,945,197,531**	**85.1%**

Notes

*Data is based on Accident and Health Policy Experience Exhibit (A&H Policy Exhibit) filings made by the companies and their subsidiaries with the National Association of Insurance Commissioners (NAIC). In the A&H Policy Exhibits, data about comprehensive medical insurance sold to individuals is under the heading "Individual, Comprehensive Major Medical With Contract Reserves." Data about comprehensive medical insurance sold to small employers (usually between 2-50 employees) is reported under the heading "Group Business Comprehensive Major Medical, Single Employer, Small Employer." Data about major medical insurance sold to large employers is reported under the heading "Group Business Comprehensive Major Medical, Single Employer, Other Employer."

*NAIC's calculation of Loss Ratio is "Paid Claims plus Change in Contract Reserves" divided by "Earned Premiums." The change in contract reserves generally does not significantly affect the loss ratio, but is included in the above calculations.

*Data is limited to fully-insured business, comprehensive major medical insurance. Self-insured, administrative-services only, FEHB, Tricare and Medicare are not included in this chart.

*Data does not include information about entities regulated by the California Department of Managed Health Care (DMHC), because such entities do not file A&H Policy Exhibits with NAIC. Companies that have substantial amounts of major medical business and file with DMHC include, but are not limited to: Blue Cross of California (a WellPoint subsidiary) and PacifiCare of California (a UnitedHealth subsidiary).

*In 2009, Golden Rule, a UnitedHealth subsidiary, sold the bulk of its individual insurance through associations and other groups, therefore it is not represented as Individual Business in the A&H Policy Exhibit, but rather is reported as "other associations and discretionary trusts." The above individual number for UnitedHealth, however, includes Golden Rule premiums and claims as reported in Golden Rule's A&H Policy Exhibit. Without Golden Rule, UnitedHealth's individual premiums would be $629,060,549, its claims would be $530,783,524, and its loss ratio would be 84.3%. This would increase the total group ratio to 75%.

Premiums, Claims, and Loss Ratios

Comprehensive Major Medical Insurance for the 6 Largest Public Insurance Companies (2008)

	Individual			Small Employer			Large Employer		
	Premiums	*Paid Claims + Change in Contract Reserves*	***Loss Ratio***	*Premiums*	*Paid Claims + Change in Contract Reserves*	***Loss Ratio***	*Premiums*	*Paid Claims + Change in Contract Reserves*	***Loss Ratio***
Aetna	$843,692,044	$623,084,229	**73.9%**	$8,875,867,031	$7,282,001,694	**82.0%**	$5,459,969,978	$4,479,111,894	**82.0%**
CIGNA	$61,571,932	$53,515,318	**86.9%**	$0	$0	--	$12,609,503	$4,689,330	**37.2%**
Coventry	$121,003,570	$79,610,830	**65.8%**	$942,048,835	$744,761,391	**79.1%**	$2,108,245,345	$1,743,470,356	**82.7%**
Humana	$464,653,831	$334,037,576	**71.9%**	$2,556,931,493	$1,974,696,888	**77.2%**	$2,831,401,783	$2,332,915,906	**82.4%**
UnitedHealth	$1,590,952,160	$1,118,978,059	**70.3%**	$8,464,932,032	$6,658,701,925	**78.7%**	$13,421,315,270	$11,203,629,006	**83.5%**
WellPoint	$4,760,267,838	$3,479,737,544	**73.1%**	$7,106,213,785	$5,615,971,146	**79.0%**	$17,148,822,998	$14,607,861,149	**85.2%**
Total	**$7,842,141,375**	**$5,688,963,556**	**72.5%**	**$27,945,993,176**	**$22,276,133,044**	**79.7%**	**$40,982,364,877**	**$34,371,677,641**	**83.9%**

Notes

*Data is based on Accident and Health Policy Experience Exhibit (A&H Policy Exhibit) filings made by the companies and their subsidiaries with the National Association of Insurance Commissioners (NAIC). In the A&H Policy Exhibits, data about comprehensive medical insurance sold to individuals is under the heading "Individual, Comprehensive Major Medical With Contract Reserves." Data about comprehensive medical insurance sold to small employers (usually between 2-50 employees) is reported under the heading "Group Business Comprehensive Major Medical, Single Employer, Small Employer." Data about major medical insurance sold to large employers is reported under the heading "Group Business Comprehensive Major Medical, Single Employer, Other Employer."

*NAIC's calculation of Loss Ratio is "Paid Claims plus Change in Contract Reserves" divided by "Earned Premiums." The change in contract reserves generally does not significantly affect the loss ratio, but is included in the above calculations.

*Data is limited to fully-insured business, comprehensive major medical insurance. Self-insured, administrative-services only, FEHB, Tricare and Medicare are not included in this chart.

*Data does not include information about entities regulated by the California Department of Managed Health Care (DMHC), because such entities do not file A&H Policy Exhibits with NAIC. Companies that have substantial amounts of major medical business and file with DMHC include, but are not limited to: Blue Cross of California (a WellPoint subsidiary) and PacifiCare of California (a UnitedHealth subsidiary).

*In 2008, Golden Rule, a UnitedHealth subsidiary, sold the bulk of its individual insurance through associations and other groups, therefore it is not represented as Individual Business in the A&H Policy Exhibit, but rather is reported as "other associations and discretionary trusts." The above individual number for UnitedHealth, however, includes Golden Rule premiums and claims as reported in Golden Rule's A&H Policy Exhibit. Without Golden Rule, UnitedHealth's individual premiums would be $585,335,682, its claims would be $485,607,210, and its loss ratio would be 82.5%.

*NAIC data includes full year financial data for companies acquired by Humana rather than just the data following their acquisition. The NAIC data does not include Humana's Puerto Rico operations.

Premiums, Claims, and Loss Ratios

2009 Comprehensive Major Medical Insurance for WellPoint by Entity

	Individual			Small Employer			Large Employer		
	Premiums	*Paid Claims + Change in Contract Reserves*	***Loss Ratio***	*Premiums*	*Paid Claims + Change in Contract Reserves*	***Loss Ratio***	*Premiums*	*Paid Claims + Change in Contract Reserves*	***Loss Ratio***
Community Ins Co	$23,499,705	$21,845,119	**93.0%**	$987,666,507	$801,744,999	**81.2%**	$1,605,530,292	$1,412,451,513	**88.0%**
Rocky Mountain Hospital & Medical	$336,357,425	$249,132,268	**74.1%**	$381,099,017	$304,393,732	**79.9%**	$333,152,526	$276,882,822	**83.1%**
Anthem Ins Co Inc	$260,332,141	$184,551,780	**70.9%**	$580,546,576	$469,966,746	**81.0%**	$792,694,839	$653,475,202	**82.4%**
Anthem Hlth Plans of ME Inc	$64,356,120	$61,258,832	**95.2%**	$181,032,818	$157,380,105	**86.9%**	$528,333,440	$472,976,576	**89.5%**
Anthem Hlth Plans of NH	$76,196,081	$47,936,019	**62.9%**	$78,813,300	$69,292,046	**87.9%**	$84,806,913	$74,990,064	**88.4%**
BCBS of WI	$66,614,847	$55,697,857	**83.6%**	$24,305,190	$18,237,685	**75.0%**	$49,026,435	$42,538,996	**86.8%**
BCBS of GA Inc	$531,962,979	$401,506,043	**75.5%**	$249,572,281	$194,714,563	**78.0%**	$702,341,574	$604,085,050	**86.0%**
Empire Healthchoice Assur Inc	$25,897,259	$21,131,850	**81.6%**	$806,978,868	$764,724,074	**94.8%**	$0	$0	**0.0%**
Anthem Hlth Plans Inc	$196,602,444	$163,032,215	**82.9%**	$589,106,618	$523,079,155	**88.8%**	$1,428,511,843	$1,259,628,898	**88.2%**
Anthem Blue Cross Life & Hlth Ins Co	$1,118,315,756	$808,793,094	**72.3%**	$1,034,806,505	$826,402,692	**79.9%**	$1,215,925,607	$1,027,064,085	**84.5%**
Unicare Hlth Ins Co Of The Midwest	$81,508,256	$64,307,418	**78.9%**	$182,677,501	$148,295,086	**81.2%**	$50,755,273	$40,671,273	**80.1%**
Anthem Hlth Plans of VA Inc	$650,500,576	$469,218,427	**72.1%**	$813,392,436	$541,715,642	**66.6%**	$851,283,871	$675,712,717	**79.4%**
Healthy Alliance Life Ins Co	$199,963,052	$134,192,471	**67.1%**	$456,969,951	$341,259,617	**74.7%**	$570,167,870	$471,913,230	**82.8%**
Unicare Life & Hlth Ins Co	$307,814,144	$260,206,151	**84.5%**	$124,193,773	$94,658,872	**76.2%**	$364,552,333	$326,230,630	**89.5%**
Anthem Hlth Plans Of KY Inc	$320,685,521	$254,502,443	**79.4%**	$391,869,464	$316,837,677	**80.9%**	$465,708,674	$381,657,260	**82.0%**
Peninsula Hlth Care Inc	$345,537	$209,368	**60.6%**	$35,761,228	$26,294,813	**73.5%**	$42,378,462	$32,493,285	**76.7%**
Healthkeepers Inc	$2,156,038	$1,993,640	**92.5%**	$233,021,967	$165,271,378	**70.9%**	$332,689,093	$276,336,819	**83.1%**
Hmo MO Inc	$4,461,097	$3,548,163	**79.5%**	$124,384,441	$91,720,815	**73.7%**	$105,206,671	$84,112,744	**80.0%**
Unicare Hlth Plans of TX Inc	$0	$0	**0.0%**	$791,751	$416,069	**52.6%**	$48,044,912	$43,877,764	**91.3%**
Empire Healthchoice HMO Inc	$120,843,480	$82,557,052	**68.3%**	$527,781,335	$489,725,199	**92.8%**	$422,659,379	$338,330,181	**80.0%**
Hmo CO Inc	$922,372	$1,162,632	**126.0%**	$13,321,176	$15,460,426	**116.1%**	$263,458,857	$238,205,532	**90.4%**
UNICARE Hlth Plans of the Midwest	$0	$0	**0.0%**	$5,928,114	$4,467,898	**75.4%**	$252,819,505	$209,216,749	**82.8%**
Matthew Thorton Hlth Plan Inc	$0	$0	**0.0%**	$215,531,480	$187,979,497	**87.2%**	$173,490,811	$150,753,534	**86.9%**
Compcare Hlth Serv Ins Corp	$38,999,862	$31,265,295	**80.2%**	$133,824,542	$109,618,006	**81.9%**	$223,186,203	$199,370,510	**89.3%**
Healthlink Hmo Inc	$145,294	$61,891	**42.6%**	$0	$0	**0.0%**	$0	$0	**0.0%**
Priority Hlthcare Inc	$513,803	$438,805	**85.4%**	$42,179,053	$29,030,366	**68.8%**	$77,140,290	$58,445,090	**75.8%**
BCBS Hlthcare Plan of GA Inc	$64,896	$20,460	**31.5%**	$463,050,750	$357,596,933	**77.2%**	$856,213,244	$699,889,480	**81.7%**

Notes to "2009 Comprehensive Major Medical Insurance for WellPoint by Entity"

*Data is based on Accident and Health Policy Experience Exhibit (A&H Policy Exhibit) filings made by the companies and their subsidiaries with the National Association of Insurance Commissioners (NAIC). In the A&H Policy Exhibits, data about comprehensive medical insurance sold to individuals is under the heading "Individual, Comprehensive Major Medical With Contract Reserves." Data about comprehensive medical insurance sold to small employers (usually between 2-50 employees) is reported under the heading "Group Business Comprehensive Major Medical, Single Employer, Small Employer." Data about major medical insurance sold to large employers is reported under the heading "Group Business Comprehensive Major Medical, Single Employer, Other Employer."
*NAIC's calculation of Loss Ratio is "Paid Claims plus Change in Contract Reserves" divided by "Earned Premiums." The change in contract reserves generally does not significantly affect the loss ratio, but is included in the above calculations.
*Data is limited to fully-insured business, comprehensive major medical insurance. Self-insured, administrative-services only, FEHB, Tricare and Medicare are not included in this chart.
*Data does not include information about entities regulated by the California Department of Managed Health Care (DMHC), because such entities do not file A&H Policy Exhibits with NAIC. Companies that have substantial amounts of major medical business and file with DMHC include, but are not limited to Blue Cross of California (a WellPoint subsidiary).